FEATURE

# THERAPEUTIC RECREATION — A CONCEPTUAL CRITICISM

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*This paper has been written as a contribution to the attainment of integration in the field of special recreation. It is an attempt to conceptualise recreation for the disabled against a background of the therapeutic model, in order to stimulate debate on the matter. The intention of the argument is to present a description of 'therapy' and 'recreation' current in Australian society; to show that these concepts are fundamentally different to one another; and to conclude that the concepts cannot be combined in the manner demanded by therapeutic recreation.*

Over recent years in Australia, increasing concern has been expressed for the position of 'special' populations, particularly the disabled, with respect to recreation. Services are being developed within specialised agencies, by general recreation organisations, by municipal councils, hospitals and other community centres. Courses are offered in a number of tertiary institutions, and governments at all levels are experiencing pressure to develop statements of policy on the subject.

It is important that this movement grows rapidly in order to bridge a real gap in existing services, however it is also important that such growth is founded upon sound principles. Already within the area of tertiary courses for undergraduates and graduates in recreation there is evidence of divergence and even conflict in approach. This is not necessarily bad, and in fact, in a pluralist society, such diversity is to be expected. Nevertheless, the field will also benefit from a degree of integration at the conceptual level in order that growth can retain some degree of logical consistency and direction.

To the person in the street, the concept of therapy conjures up a picture of a process which is directed at 'treating' or 'correcting' individuals who have been defined as deviating in one way or another from the norms of society. Such deviance could include physical or mental disability, physical or mental illness, social deviance or even financial disadvantage. No matter what form this deviation from the norm takes, the appropriate process demanded by the traditional school of therapy is to direct action at the individual — to re-build the client.

There is, however, developing a school which says that such a view of treatment is no longer appropriate in all circumstances. This alternative view demands that we do not label the individual's behaviour or condition as being deviant until it is assessed against the norm demanded by society. When such a comparison is made, we are then free to conclude that it may be the society's standards which should be considered pathological, and that the individual's condition would not be labelled deviant were society's view of normality broader and more flexible than it is at present.

The technique of cultural comparison developed by anthropology can make a valuable contribution to this discussion as the following passage from Peter Brent's (1972) *"Goodman of India"* indicates,

> *"In India . . . a range of behaviour is permitted which stretches well over the borders of what we would call madness. As a result, the schizoid and the paranoic have an area within society in which they can operate and usefully connect with their fellow citizens. This is not to say that they [are] tolerated for [their] supposed innocence, but rather that the ideas society has about the cosmos can accommodate a vast number of assumptions of omnipotence, obsessions, eccentricities, distortions of perception..."*
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> *"We give our mad no opportunity to compromise with their delusions; instead we put them behind walls as if to drive them farther into their personal universe. But the Indian remains and finds his delusions accepted, part of a common mythology."*
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> *"In contrast to the Indian, our concept of 'reality' seems very narrow, narrower than that held by the majority of the people in the world..."*

Burton Blatt (1973) expresses his views along these lines as well,

> *"In the beginning, humans were created, and then humans created criteria for being human... Then humans discovered their hands and their fingers . . . and sought new understandings of themselves, their relationships with others and with a higher being."*
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> *"And all the while, criteria and new criteria were invented and stipulated, first to classify, then to separate and set aside . . ."*

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*"People with special characteristics — the blind, the deaf, the retarded, the special for a time, or the special irrespective of time or culture — became consistent targets for those who would separate one human being from another."*

From these passages and from our own observations, it is clear that our view of normality does remain relatively narrow, and that the definition of therapy with greatest currency is still the traditional form which directs its focus of treatment at the individual. It is this view of therapy which the therapeutic recreation movement combines with the concept of recreation and applies in a wide variety of settings to the disabled. Before analysing the main elements of therapeutic recreation, some brief comments should be made about the state of recreation in Australia. Recreation is not new to mankind. In one form or another, human beings have always been at play; have always taken time to do the things which please and fulfil them; have always spent their leisure hours in what we call recreation. Recreation as a pursuit is not new, but in Australia as a social discipline, as a profession, it is a relatively recent phenomenon. The catch cry "recreation for all" is seen by voluntary agencies, by government and by commercial interest as being a worthy and achievable goal. It is also seen by citizens, young and old, as being an integral part of what we glibly call "the leisure age". In other words, recreation now has the sociological status of an institution. What was once a private and personal matter has become an issue of public concern, and as with other social institutions, standards have been set and ideal levels of participation promoted to all sections of the community.

## RECREATION AND THE DISABLED

What of those we collectively refer to as the 'handicapped'. Those individuals who, by the possession of some physical or mental disability, are rendered at a disadvantage in making use of the opportunities offered by society for participation, satisfaction and achievement. Does "recreation for all" cover this group as well? If so, what account must be taken of their being handicapped before the payoffs, expected of recreation can be realized for that group? Certainly, when faced with such a question we would agree that recreation is the right of all, but it is my observation and experience that, for the handicapped, we fulfil the promise of recreation in word only, not in spirit.

In Australia, care of the handicapped is dominated by the medical model. There are exceptions, but, by and large, habilitation is the aim and therapy is the strategy. Residential institutions are frequently referred to as hospitals. The bedroom is the ward. The standard mode of transportation is the ambulance. The day to day status of the handicapped individual is not 'resident' but 'patient'. All aspects of life fall within one treatment mode or another. We do not seem to recognise that, however severely handicapped an individual may be, there are some aspects of his or her life which simply are not available for therapy. One such aspect, I will maintain, is the right to recreate in one's own way; and within limitations which one must accept for one's self. In saying this, I do not deny that for many disabled, individual therapy performs a valuable and necessary function. But I do maintain that recreation cannot, by definition, be a matter of therapy, and must not, if one of the last frontiers of privacy of the disabled person is to remain intact.

If the concept of recreation is analysed, three different elements can be identified. The first is the recreation *outcome*. This is primarily subjective and can be better described by the term "the leisure attitude". Although I am sometimes interested in achieving certain objective results from my recreation experience, for example increase in certain skills, it is still true that the hallmark of recreation is the way I *feel* about my activity. This feeling or attitude is one which says that in time which is not otherwise committed, I will achieve things and enjoy experiences which are pleasing and satisfying to me, for my own reasons. I may share these experiences with others and I may agree to act within certain limitations, but it is my attitude to recreation that is central, and this attitude is largely one of self-satisfaction.

The second element can be labelled *focus*. This simply demands that recreation is not undirected (the focus of recreation is often referred to as the "activity" but this term does tend to imply physically active pursuits — thus preference for the term "focus"). In recreation we do have a goal, however loosely defined and flexibly employed. Our interest and action is directed towards some consciously identified focus, the pursuit of which we expect will result in the desired sense of satisfaction or achievement. It is also true of recreation that its focus is interchangeable on the basis of how we feel. There may of course be limitations on the number of choices we can make — economic, legal or moral, to name but a few — but in theory, at least, the focus is interchangeable on the basis of its subjective outcome.

The third element intrinsic to the concept of recreation is the process of *choice*. This element is crucial as recreation demands a freedom, albeit relative, to change, modify and adjust one's goals. It is clear that the process must rest with the recreating individual. It cannot be vested in anyone else. If I recreate, I must have the right and the opportunity to choose. As stated above, this analysis does not claim that choice in recreation is unlimited. In considering the disabled, those limitations may be substantial, even overwhelming,

but the principle remains intact. In recreation, the choice within whatever limitations may obtain, must remain with the individual.

A similar analysis under the headings of outcome, focus and choice can also be applied to the concept of therapy. Firstly, under the heading of outcome, it is right to claim that therapy must be "good for the patient". Certainly I choose recreational pursuits because they are good for me; but good for me in a purely *subjective* sense —what makes me *feel* good, *feel* satisfied and fulfilled. Therapy may be good in this sense as well, but primarily it is good in an *objective* sense. In the last analysis, therapy must be good independently of the feelings or attitudes of the individual on whom it is practised. The distinction is a fine one but it is nevertheless present. Objective therapy, to be effective, must certainly take account of the individual's subjective state, but most essentially its goodness is in its objectivity. For recreation, goodness is primarily in its subjectivity.

Therapy also contains the element of focus or activity and in many cases, the activity of therapy is quite indistinguishable from many activities undertaken as recreation. In therapy, the focus is also interchangeable but on the basis of its objective, not its subjective effects. The focus of therapy is deliberately chosen because it is expected that certain benefits to the individual will accrue. In recreation the same applies, but a change can be made in recreation mid-stream with the expectation that the same, or similar satisfactions, will be forthcoming for the recreator. In recreation, I may choose sewing or swimming with the expectation of achieving a desired state of relaxation and enjoyment. In therapy it is unlikely that sewing and swimming can be interchanged in the same way in order to achieve the same objective end.

The third element, choice, is also shared by the two concepts. In therapy, however, the choice must lie with the therapist. Under the medical model, the therapist makes certain decisions or choices on behalf of the individual, which are designed to achieve certain ends with which the individual concurs. The individual may agree with the choice but does not — in fact, cannot — make the choice.

Of course therapy may continue to the point at which the individual is able to make appropriate decisions. Nevertheless, such decisions must be made on the basis of the objective outcome of therapy, rather than of the type made in recreation, which has a subjective outcome in view.

These distinctions may be represented diagramatically as shown in figure 1.

| | Therapy | Recreation |
|---|---|---|
| Out-come | Objective (attitude secondary) | Subjective (attitude primary) |
| Focus | interchangeable in terms of objective effect | interchangeable in terms of subjective effect |
| Choice | rests with the therapist | rests with the individual |

FIGURE 1

Now, what is the effect of combining these concepts of therapy and recreation into the now well-known term of therapeutic recreation? If therapeutic recreation, means no more than recreation for the hospitalised and disabled, then there is no argument. But the term does mean more than that. The following definitions of therapeutic recreation clearly embody an attempt at synthesis between the concepts of therapy and recreation. However, this attempt does not work, simply because the final result does not embody the essence of recreation.

Definition 1 — Frye (1972)
*"Therapeutic Recreation is a process through which purposeful efforts are directed toward achieving or maximising desired concomitant effects of a recreation experience.*

Definition 2 — Avedon (1970)
*"Therapeutic Recreation is a matrix of assistance calculated to contribute to the modification and amelioration of the inhibiting disorder".*

Definition 3 — Sheridan (1976)
*"Therapeutic Recreation can be described as an outgrowth of (1) society's use of recreation to prevent dysfunction which results from lack of opportunities for recreation experience amongst special groups; and (2) the use of traditional recreation activity in the treatment of any illness or disability".*

Definition 4 — Rusalem (1973)
(A statement about therapeutic recreation)
*"In therapeutic recreation, the medium used to effect change is selected leisure activities and experiences."*

The first two definitions, those of Frye and Avedon, emphasise the beneficial effects of therapeutic recreation. The second two definitions, those of Sheridan and the statement by Rusalem, stress the use of particular activities in achieving the desired effect. These two emphases embody, to my way of thinking, the key to the failure of therapeutic recreatiion in its attempt to link the two concepts. To take first of all the thrust of the first two definitions; that is the emphasis on beneficial effects.

We are familiar with the use of the term therapy to describe the beneficial effects of some forms of treatment. A wide range of professions, largely medical and allied health, are included within what could be described as the therapeutic model, all of them having, as their aim, the general improvement of the lot of the individual from one point of view or another. This use of the term therapy will be designated by the capital 'T'. There is however another sense in which the term therapy is used and that is the everyday sense of what makes me feel good, what is in a very general way 'good for me'. We say of the jog around the block in the morning that it is 'therapeutic' — we would say the same of a plunge into an icy pool after a sauna, or of a game of tennis. In fact, this term has such wide currency as to be applied to almost any personally satisfying experience.

In this sense, recreation is certainly therapeutic. In fact, the application of the term in this sense is so widespread that we do not have to attach the term therapy to the use of the word recreation; its sense is implied and fully accepted. It is clear from this distinction that the first two definitions, in applying the concept of beneficial effect, use as their reference point the definition of Therapy related to the medical model, rather than the definition of therapy which is related to recreation.

In the second two definitions, there is an emphasis upon the use of activity. Throughout our lives, we engage in many different activities and each of these activities play a different role for us depending upon the context in which they are undertaken. For example, a craft teacher can use weaving as a job; the same activity can be used for others as a form of recreation; and thirdly it can be used in the Therapeutic sense to promote small muscle co-ordination.

A second example would be the use of physical exercise. For the physical education teacher, exercise is part of the job; for another exercise in the form of jogging or circuit training can be a form of recreation. There is also the third application of using exercise to strengthen muscle groups as part of a rehabilitation programme. Even the major sports can be seen in this light. For example, swimming for professional swimmers entering international competition is different to swimming as a recreation, and these two are different again from the use of the activity swimming as a Therapy, for example, for asthmatic children. In each case, the activity is the same but its context is different and thus its effect changes from one situation to another. The two definitions which use activity in describing therapeutic recreation do so quite clearly in the third and Therapeutic sense, not as recreation.

Now, in applying this analysis of therapeutic recreation to the original distinctions made in the above chart between Therapy and recreation, it can be seen that Frye and Avedon are using the beneficial effect or outcome in therapeutic recreation in the objective sense demanded by the definition of Therapy, rather than in the subjective sense embodied in the definition of recreation. Similarly, the definitions of Sheridan and Rusalem place the use of activity within the Therapeutic definition rather than within that applying to recreation.

The third element, the concept of choice now remains to be dealt with. This concept, as such, does not appear in definitions of therapeutic recreation, but it is dealt with by such workers as O'Morrow (1976) in their description of the therapeutic recreation process. O'Morrow states that:

*". . . the therapeutic recreation specialist should designate possible activities for each behavioural problem. This requires that the specialist know which activity is appropriate for a dependent, a semi-dependent or independent member; which is appropriate for an acutely ill, a chronically ill, a convalescent or an aged member."*

In this statement, it is clear that O'Morrow views the process of choice to be a function of the therapeutic recreation specialist. It is the therapist who makes the choice because it is the therapist who knows what activities will achieve the desired outcome. This is consistent with other findings from the analysis of the concept of therapeutic recreation.

In analysing the concept, it is clear that therapeutic recreation is based upon the Therapeutic model. In fact, it is none other than a Therapeutic process and the only concession it allows to recreation is the use of some techniques of the recreationalist, and many activities which are commonly labelled recreational. However, we have seen that such activities are not intrinsically either recreational or Therapeutic but have the potential for either outcome, depending upon the context in which they are applied. Activities themselves form a necessary but certainly not sufficient condition for either recreation or Therapy. The way they have been applied in the field of therapeutic recreation is clearly under the guidelines dictated by Therapy.

Now, the problem is not that the process of therapeutic recreation is inappropriate to the disabled. There is no doubt that, in many cases, it makes a valuable if not an essential contribution to the lives of those to whom it is applied. The problem lies in the assumption that therapeutic recreation will facilitate the outcomes of recreation for the disabled in the same way as our recreation does for us. But if therapeutic recreation is applied according to the Therapy model, then this result does not automatically accrue. In fact, what we have in many cases is a programme called

recreation which is based upon the need to do something good for the individual, to select activities which will have a beneficial effect and to assume that the therapeutic recreationalist, in working with the disabled, is in the best position to make the recreational choices. Well, that's not the case with the non-disabled — the so-called normal population. In large part, the recreation of the non-disabled is a very private and personal matter. Most people do those things in recreation which make them feel good, which bring to them personally important feelings, which give them opportunities for achievement not accruing in other areas of life.

It was proposed earlier in this paper that recreation was the right of all, and that the disabled must be considered to be part of that 'all'. It is clear that, from the above analysis, at best therapeutic recreation is in danger of not being able to fulfil this role to the same extent that recreation programmes do for the non-disabled; and at worst, that the existence of the field of therapeutic recreation lulls us into a sense of satisfaction that the disabled really are being catered for in this area, that they can in fact have the opportunities we have for exercising choice in their own regard, of pursuing just those activities which are most meaningful to them and for having access to those personal feelings of satisfaction which are so important to the non-disabled population.

There certainly are problems in applying this definition of recreation to the disabled. For example, to what extent are severely and profoundly retarded people capable of the process of choice; and just how meaningful is a wide range of recreational options to a quadraplegic. Although these difficulties exist, I believe the principle must remain intact, and that the area of recreation is an aspect of the life of the disbled which is simply not available for Therapy.

The focus of the argument this far has been to show what differences exist between Therapy and recreation, and why therapeutic recreation, due to these differences, must be considered as an internally inconsistent concept. The view of recreation argued above is one which takes account of disability, but only in as much as it presents the recreating individual with a limitation to his or her activity. Recreation, in this view, accepts the disability and does not, as with Therapy, attempt to modify it in any direct or primary way. Recreation's task is to give the individual the opportunity for deciding that which will give a sense of satisfaction and enjoyment and to provide the opportunities to make that possible. For this process to succeed we must assume that the individual can recreate NOW — not at some later date when some changes have been made. Thus in recreation, the disability itself must be considered a constant.

As a recreationalist, I cannot concern myself with the disability except in as much as it imposes limitations on recreational opportunities. My concern is with the individual who happens to possess a substantially disabling condition. I am not insensitive to the need for treatment of the primary disability and I am aware that some so-called recreational activities often prove very valuable in treatment, but if we have an aim of modifying the primary disability then we must, broadly speaking, follow a Therapeutic model. To do this will necessarily deny some of the basic tenets of recreation. This distinction is made clear by Paul Haun (1971) in debating the legitimacy of therapeutic recreation. He says:

> *"The hospital recreation worker performs many services essential in my opinion, to the welfare of the patient. I cannot, however, regard any of them as therapeutic, first because I have never been convinced that recreation in any of its forms is a specific instrument for the modification of a disease process . . . [and] second, because I am so fully persuaded of the . . . patient's need for recreation as recreation I grudge any dilution of its potency through adulteration with alternative purposes."*

Haun claims that recreation is a pure and basic process as it is, and that to place it within the medical model, as the therapeutic recreation movement does, is not a helpful exercise. Handicapped people can recreate, and they can recreate *now*, albeit with limitations.

Therapeutic recreation is based on a medical model which demands changes to recreation which remove from it some of its essential elements — the subjectivity of its purpose, the interchangeability of its focus, and most importantly the locus of choice. I contend that not only is this unnecessary but it is also a process which will force continuing dependence upon people for whom independence, however slight, is of vital importance. Dignity is not lost by being dependent, but by remaining dependent when that need not be the case. Recreation gives the opportunity of independent decision-making, and with that independence comes the dignity we have as human beings.

In recreation we have needs which require satisfaction. The awareness of those needs and the desire for satisfaction is the motivational force behind our drive for fulfilment through recreational experiences. In a variety of social and physical situations, the recreationalist's aim is to enable the disabled individual to practise this process of self-awareness, to understand albeit to begin with at a simple level, the consequences of choice. These are the fundamentals of recreation. They are personal matters, individual matters, and are not open to manipulation if they are to remain intact as the private property of the individual.

Therapy, and recreation, are for all people distinct process. For the disabled, that distinction must remain even though both must often proceed together throughout the whole of life.

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